

**Evrysdi (risdiplam), Spinraza (nusinersen)****Member and Medication Information (required)**

Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

**Provider Information (required)**

Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

**FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992**

**Criteria for Approval (all must be met):**

- ☐ Evrysdi: patient is 2 months of age or older
- ☐ This medication is prescribed by or in consultation with a physician who specializes in spinal muscular atrophy (SMA) treatment.
- ☐ Patient has documented:
  - ☐ SMA caused by mutations in chromosome 5q leading to SMN protein deficiency **OR**
  - ☐ Spinraza: Presymptomatic SMA treatment with homozygous gene deletion of SMN1 AND 2 or 3 copies of SMN2
- ☐ Assessment of motor function development milestones using age-appropriate screening tools.
- ☐ Patient has not previously received Zolgensma.

**Additional criteria for Spinraza:**

- ☐ Date of the last Spinraza treatment, if applicable: \_\_\_\_\_

**Re-authorization Criteria:**

- ☐ Updated letter of medical necessity or updated chart notes demonstrating response indicated below:

**Evrysdi Authorization:** Up to one (1) year

**Spinraza Authorization:** 4 doses over 58 days, then 1 dose every 4 months, up to one year

**Re-authorization:** Up to one (1) year

**Note:**

- ❖ Initiate SPINRAZA treatment with 4 loading doses; the first three loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose; a maintenance dose should be administered once every 4 months thereafter.
- ❖ Use appropriate HCPCS code for billing  
Coverage and Reimbursement code look up: <https://health.utah.gov/stplan/lookup/CoverageLookup.php>  
HCPCS NDC Crosswalk: <https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php>

**PROVIDER CERTIFICATION**

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date